BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

JUSTIN D. HAWKINS	)	
Claimant	)	
V.	)	Docket No. 1,064,097
	)	
GOODYEAR TIRE & RUBBER COMPANY	)	
Self-Insured Respondent	)	

ORDER

Claimant, by and through George H. Pearson, of Topeka, requested review of Administrative Law Judge Rebecca Sanders' October 14, 2014 Award. Brent M. Johnston, of Kansas City, appeared for the self-insured respondent (respondent). The Board heard oral argument on February 10, 2015.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the Award's stipulations. The parties stipulated the Board may consult the AMA *Guides*[1] (hereafter *Guides*).

ISSUES

Claimant alleges he injured his left knee and "tailbone"[2] on August 31, 2012. The judge concluded claimant sustained a 5% permanent functional impairment to his left leg, but did not sustain personal injury to his tailbone. The judge also ruled claimant did not prove he would need future medical treatment.

Claimant requests the Award be modified, arguing he proved a compensable injury resulting in a 5% whole body impairment for his tailbone injury and a 7.5% impairment to his left lower extremity. Claimant also argues the judge erred in denying him future medical treatment. Respondent maintains the Award should be affirmed.

The issues are:

1. Did claimant sustain personal injury to his tailbone?

2. What is the nature and extent of claimant's disability?

3. Is claimant entitled to future medical treatment?

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[1] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based on the fourth edition of the *Guides*.

[2] R.H. Trans. at 19. While the record references the coccyx, sacrum and "sacrococcygeal difficulty," we will sometimes use the term "tailbone" to refer to claimant's injury.

FINDINGS OF FACT

On August 31, 2012, claimant was stepping down from a machine on a raised platform at work when his left knee twisted or rolled and he fell, hitting his tailbone on the concrete floor. Claimant had immediate shooting pain in his left knee and tailbone.

Initially, claimant treated at respondent's dispensary. Respondent referred claimant to Lowry Jones, M.D., a board certified orthopedic surgeon. Dr. Jones evaluated claimant on October 30, 2012. Claimant presented with low back and left knee pain. Dr. Jones' physical examination showed claimant had low back and tailbone pain, with sciatic notch and SI joint tenderness on the left. Straight leg raise testing was moderately positive on the right, but more significant on the left. Pain limited claimant's lumbar spine range of motion. Claimant had sharp pain in the left patellofemoral joint. Dr. Jones reviewed MRI scans and found no specific ligamentous and/or meniscal injury of the knee and noted no significant abnormality of the lumbar spine.

Dr. Jones diagnosed claimant with an articular cartilage injury to the patellofemoral joint and acute lower back pain with radicular symptoms. Dr. Jones noted claimant did not have evidence of a herniated disc, but his presentation was suggestive of a "nerve root injury or stretch injury."[3] Dr. Jones injected claimant's knee. Dr. Jones does not treat backs and recommended claimant be referred to a doctor in his office specializing in physiatry for non-operative back treatment, including an injection. Dr. Jones' initial report contained a paragraph titled "Causation" that stated:

> As a direct result of the injury that he sustained on [or] about 8/30/2012 he has injured his left knee and his lower back. The prevailing cause for the need for additional medical treatment is the injury. I have injected his left knee, recommend evaluation with a physiatrist for his back and we will follow him up for his left knee after treatment of his back.[4]

Dr. Jones restricted claimant against repetitive bending at the waist, repetitive lifting below knee level, repetitive kneeling, squatting and climbing, and suggested he alternate positions for pain control.

At respondent's request, claimant saw Alexander Bailey, M.D., a board certified orthopedic surgeon, on February 12, 2013. Claimant presented with continuing tailbone pain radiating into his low back, left thigh and calf. Regarding the history of claimant's injury, Dr. Bailey indicated claimant's knee gave out, he fell to the ground, rolled over and got up quickly because there were a lot of trucks driving around the plant. With respect to his physical examination, Dr. Bailey's report states:

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[3] Jones Depo., Ex. 2 at 15.

[4] *Id.*, Ex. 2 at 15.

> On physical exam, well-developed, well-nourished, pleasant 30-year-old gentleman. He is awake, alert and oriented x3. He ambulates around the room favoring his left leg, holding the knee. He has limited strength in that left lower extremity. He is guarding his left knee even holding it during the entire exam. He seems to have equal strength but once again he is protecting it. Deep tendon reflexes are 2+ and symmetric except for the left knee. I avoided that due to the patient's pain. Straight leg raise is negative for leg pain.[5]

Dr. Bailey reviewed tailbone x-rays which showed aligned joint spaces in claimant's lower coccyx and no gross evidence of dislocation or evidence of bony erosion, periostitis or any other significant abnormality. He concluded claimant's lumbar spine MRI was normal. Dr. Bailey's assessment was: (1) status post fall with knee pain and (2) generalized complaints of coccygeal and lumbosacral pain without evidence of significant abnormality on clinical examination or objective imaging studies. Dr. Bailey stated:

> This patient sustained a fall. He purportedly has injured his knee and this is being evaluated and treated. The patient subsequently complained of some back pain over time. His MRI scans are negative. Coccyx x-rays are negative and subjective complaints of coccygeal pain and lumbosacral pain are entirely subjective in nature. Coccygeal pain can develop from a direct contusion or trauma but given his overall objective findings, limited treatment options are available. Given the timeframe, the fall and relatively negative studies, I do not find a correlation between the patient's work-related fall and his current complaints with relatively negative studies. I believe this patient's primary abnormality and complaint is of his knee with little findings of significance in the lumbosacral spine or sacral coccygeal area.[6]

Dr. Bailey opined physical therapy would not provide claimant significant relief and an injection or surgery was too risky because of the risk of infection.[7] Dr. Bailey testified claimant was at maximum medical improvement (MMI) and did not need any further treatment related to the lumbosacral spine and coccyx. He testified claimant could return to his regular work.

On March 5, 2013, claimant returned to Dr. Jones. Claimant noted the knee injection only gave him temporary relief and his knee pain returned to where it was before. Dr. Jones continued claimant's restrictions of no repetitive kneeling, squatting or climbing, and to alternate positions for pain control. Dr. Jones recommended a left knee arthroscopy with chondroplasty. Dr. Jones noted claimant had his back evaluated, he was diagnosed with coccygeal pain and "[t]hey offered him an injection which was not completed. Dr.

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[5] Bailey Depo., Resp. Ex. B at 1-2.

[6] *Id*., Resp. Ex. B at 2.

[7] Claimant testified surgery or injections were offered, but he declined due to risk of infection. (R.H. Trans. at 12-13).

Bailey recommended no further treatment."[8] Dr. Jones' report included the same language regarding causation as had his initial report, including discussion of claimant's low back injury and recommendation for claimant to be evaluated by a physiatrist.

Dr. Jones performed the aforementioned knee surgery on April 2, 2013. Six days later, claimant reported his left knee pain had decreased. Claimant was using crutches. Physical examination revealed nearly full knee range of motion, no instability and no calf pain or swelling. Dr. Jones instructed claimant to continue a home exercise program. Dr. Jones gave claimant sedentary work restrictions.

By April 23, 2013, claimant was no longer using crutches and he had decreased his pain medication. Physical examination revealed moderate left quadriceps weakness. Dr. Jones ordered physical therapy for quadriceps strengthening and stabilizing exercises. Claimant's restrictions remained unchanged. Dr. Jones' report included the same language regarding causation as in his October 30, 2012 and March 5, 2013 reports.

On May 21, 2013, claimant told Dr. Jones he was progressing in physical therapy and was able to lift 40 of the 80 pounds required for his job. He was taking Advil daily with occasional pain medicine at night. Dr. Jones recommended claimant continue with physical therapy for strengthening and gave claimant light duty restrictions. Dr. Jones again included the "Causation" paragraph indicating a physiatrist should evaluate claimant's low back.

With regard to claimant's left knee, Dr. Jones placed him at MMI and released him to full duty without restrictions on June 11, 2013. Dr. Jones noted claimant's left knee had mild swelling and his range of motion was not quite full. Claimant did not have knee instability. Claimant was able to ambulate stairs well. The "Causation" paragraph was repeated in Dr. Jones' June 11 report. Dr. Jones did not evaluate claimant after June 11.

In a September 19, 2013 letter, Dr. Jones assigned claimant a 5% permanent partial impairment at the level of the left knee pursuant to the *Guides*. Dr. Jones indicated claimant would not require further medical or surgical treatment for his left knee injury. He also stated claimant had a low back injury that was treated by Dr. Bailey.

On October 1, 2013, at his attorney's request, claimant was evaluated by Edward Prostic, M.D., a board certified orthopedic surgeon. Claimant complained his main residual symptom was tailbone pain, which was worsened by sitting and sometimes climbing stairs, coughing or sneezing. Dr. Prostic noted claimant's "low back" injury mainly concerned his "sacrum and coccyx."[9] Claimant reported relief of most of his knee symptoms.

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[8] Jones Depo., Ex. 2 at 12.

[9] Prostic Depo. at 5.

Dr. Prostic's physical examination revealed satisfactory alignment of claimant's lumbar spine and tenderness only at the coccyx. Claimant could almost touch his toes, while extension, lateral bend and lateral rotation of the low back were within normal limits. Claimant was able to walk on his toes and heels and squat completely. Claimant's left calf was one-half inch smaller in circumference than his right calf and his left thigh was three-quarter inch smaller in circumference as compared to his right thigh. Dr. Prostic reported mild anterior crepitus in the left lower extremity with no tenderness, instability or signs of meniscal injury. X-rays revealed no abnormality in the lumbar spine and neutral alignment in the left knee with well-maintained joint space and no visible osteophytes.

Dr. Prostic noted claimant's surgery was beneficial, but claimant had "significant thigh atrophy."[10] He further noted claimant had "significant residual complaints related to his coccyx."[11] Dr. Prostic testified claimant had an injury to his coccyx that was part of his low back injury sustained on August 31, 2012. Dr. Prostic testified, "patients who have the complaint that [claimant] had usually have injury . . . either to the joint between the sacrum and coccyx or to the ligaments that attach to the coccyx. So it's usually an inflammatory condition that can be treated by injections and medicine."[12] Dr. Prostic assigned claimant a 10% impairment to the left lower extremity and 5% whole person impairment for "sacrococcygeal difficulty,"[13] for a combined 9% whole person impairment. Dr. Prostic stated the August 31, 2012 accident was the prevailing factor in claimant's injury, medical condition, need for medical treatment and resulting disability or impairment.

Dr. Prostic testified his ratings were based on the *Guides.* For claimant's left leg, Dr. Prostic utilized table 37, page 77, for an 8% lower extremity impairment for claimant's thigh atrophy. For the knee surgery, he gave a 2% lower extremity rating using table 65, page 85, which concerns a partial medial meniscectomy. Dr. Prostic testified a rating for a partial medial meniscectomy was equivalent to claimant's chondroplasty of the patella.

Regarding claimant's impairment manifested in his tailbone or coccyx, Dr. Prostic testified his 5% whole body rating was based on giving claimant "credit for DRE lumbosacral 2."[14] Dr. Prostic acknowledged finding no evidence of muscle guarding, neurological impairment or radiculopathy. In terms of "low back" findings, he only found tenderness at the coccyx and calf atrophy. Dr. Prostic was asked if claimant had any evidence of radiculopathy:

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[10] *Id*., Ex. 2 at 2.

[11] *Id*., Ex. 2 at 2.

[12] *Id*. at 15.

[13] *Id*., Ex. 2 at 2.

[14] *Id*. at 7-8; see also p. 10.

Q. Any - - you know, any evidence of radiculopathy at all?

A. No. Well, there's one sufficient for it and that's calf atrophy. But without the proper radicular symptoms I don't know what to link it to.

Q. And the calf atrophy was in the same leg the . . . surgery was done; is that correct?

A. Yes, but that's unusual.

Q. If somebody had not been able to use the leg as much, would that frequently result in deconditioning of the muscles?

A. Yes.

Q. So it wouldn't necessarily be something that would really send up a red flag if you see somebody who has a knee surgery and a short-term later has some deconditioning of that calf muscle?

A. It's unusual, but I would not say it's a red flag.[15]

Dr. Prostic testified claimant's calf atrophy "more probably than not" related to his accident.[16] He did not ask claimant if his calf atrophy was preexisting. Dr. Prostic testified his opinion regarding calf atrophy was based on "some degree"[17] of speculation because he assumed claimant's left calf was not smaller prior to the accident and only became smaller after the accident.

While Dr. Prostic acknowledged claimant would "technically fit"[18] within Lumbosacral DRE Category I, which would result in a 0% impairment, he felt it was "more appropriate"[19] and used "discretion and judgment"[20] to place claimant within Lumbosacral DRE Category II because claimant had undergone significant treatment, been off work for a significant amount of time and was still having significant symptoms one year post-injury. Dr. Prostic testified claimant "deserved" to be in DRE Category II over DRE Category I.[21]

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[15] *Id*. at 11.

[16] *Id*. at 18.

[17] *Id*. at 14.

[18] *Id*. at 12.

[19] *Id*. at 17.

[20] *Id*. at 12.

[21] *Id*.

Dr. Prostic also agreed claimant's impairment represented a "unique situation" because he had "more of a tailbone injury than a low back injury."[22] Dr. Prostic testified the *Guides* do not expressly or directly address coccyx impairment. He agreed with claimant's attorney that if the *Guides* do not address an impairment, a physician is free to formulate an opinion regarding permanent impairment.

In his report, Dr. Prostic noted it would be possible to inject the sacrococcygeal joint or adjacent ligaments with local anesthetic and corticosteroid, but advised against coccygectomy. Claimant testified Dr. Prostic discouraged him from having his tailbone surgically removed or injections based on a high rate of infection. Dr. Prostic testified claimant will require future medical care in the form of regular strengthening exercises, general aerobics and core strengthening. If such exercises were not enough, claimant could also take anti-inflammatory and analgesic medicines.

At the time of the May 8, 2014 regular hearing, claimant complained of continued soreness in his left knee, in addition to shooting pain in his tailbone when riding or sitting on hard surfaces for an extended period. Claimant testified he received no treatment to his tailbone. He continues to work for respondent performing the same job.

In a report dated June 16, 2014, Dr. Bailey stated he believed claimant had reached MMI and he assigned claimant a 0% impairment rating. He testified he used DRE Lumbosacral Category I under the *Guides.* His report stated:

> The patient has had some low back conditions, complaints and some coccygeal area sacral pain. The patient was fully evaluated with x-rays, MRIs, physical examination and was ultimately found to have negative studies and negative significant abnormalities under clinical nor objective imaging studies. I failed to identify any significant injury as described by the patient to his lumbosacral spine or coccyx. Despite full evaluation, negative findings were identified and there is no evidence of a significant issue or problem with the patient's lumbosacral spine or coccyx. It is my assessment that there was no specific injury sustained on 08/31/2012 to the lumbosacral spine or coccyx.[23]

When asked if he found any specific injury to claimant's low back or coccyx, Dr. Bailey testified he "did not find any abnormality of the lumbosacral spine or coccyx on evaluation or workup."[24] He acknowledged he only examined claimant once and did not address impairment until 16 months later. Dr. Bailey acknowledged not knowing that claimant reported shooting pain in his tailbone at the regular hearing.

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[22] *Id*. at 10.

[23] Bailey Depo., Resp. Ex. C at 1.

[24] *Id*. at 8.

Dr. Jones testified on July 29, 2014. He testified he only used table 62 of the *Guides* to rate claimant's impairment because "[t]he only thing that the patient had that was objective was his articular cartilage injury."[25] Other than a crack in the cartilage surface of the kneecap, Dr. Jones testified claimant's knee was normal, including no muscle atrophy, no functional loss and complete quadriceps strength. Dr. Jones admitted his records held no mention regarding muscle atrophy, but he insisted he would not have released claimant to return to lifting 80 pounds if he had any weakness or muscle atrophy:

> The patient was 100 percent - - make sure I said that - - 100 percent functional in all activities when he left my office, all right? That implies his muscle tone is 100 percent normal. I just want to make sure I got that number in for you.
>
> . . .
>
> I never . . . release anybody unless I believe they are fully capable of going back to the activity they had and his job required 80 pounds of lifting, which means it was a heavy duty category. You don't do that if you have weakness and muscle atrophy.[26]

In the October 14, 2014 Award, the judge stated, in pertinent part:

> Another issue in this case is whether the Claimant suffered a personal injury to his tail bone as defined in **K.S.A. (2011 Supp.) 44-508(f)(1)**. The only difference between Claimant's condition of his tail bone before and after the accident of August 31, 2012 is pain. There are no X-rays or MRIs showing that Claimant's tail bone or low back had a lesion or structural change as a result of his work accident on August 31, 2012. According to **K.S.A. (2011 Supp.) 44-508(f)(1)** having pain complaints is not sufficient to constitute a personal injury to Claimant's low back or tail bone. It is found and concluded that there was an accident that included Claimant's tail bone. However, such an accident did not result in a personal injury to Claimant's tail bone.
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> The third issue in this case is what is the nature and extent of the permanent impairment to Claimant's left knee. Dr. Prostic found that Claimant had a ten percent impairment to Claimant's left knee. That rating included atrophy in the left calf and thigh. The finding of atrophy was based on the comparison to Claimant's right thigh. However there is no indication as to whether such atrophy predated the work injury or not. This finding seems to be based on that there was left knee injury ergo that caused the atrophy. Such a finding is not convincing. Dr. Jones found Claimant had five percent impairment to the left lower extremity and was based on a table in ***The Guides*** that closely mirrored the injury Claimant had and is reflective of Claimant's injury and resulting impairment. It is found and concluded that Claimant has a five percent permanent impairment to the left lower extremity.

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[25] Jones Depo. at 19.

[26] *Id*. at 16-17.

> **K.S.A. 44-510h** as amended May 15, 2011 provides a presumption the employer's liability for medical expenses terminates upon maximum medical improvement. The presumption may be overcome with medical evidence that it is probably more true than not additional medical treatment will be required after maximum medical improvement. Additional "medical treatment" does not include home exercise programs or over-the-counter medications.
>
> There is insufficient evidence to rebut the presumption that liability for medical expenses by Respondent terminates when Claimant reaches maximum medical improvement. The only reference to future medical was from Dr. Prostic who recommended strengthening and aerobic exercise. There was no specific mention that these exercises must be formal physical therapy program supervised by a physical therapist. Dr. Prostic also recommended analgesics and anti-inflammatories. Claimant is currently not taking medication. There is no specific recommendation that the anti-inflammatories or analgesics could not be over the counter medication. Therefore Claimant's request for future medical treatment is denied.[27]

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2012 Supp. 44-551(i)(1) states, in part:

> [T]he board shall have authority to grant or refuse compensation, or to increase or diminish any award of compensation or to remand any matter to the administrative law judge for further proceedings.

Board review of a judge's order is de novo on the record.[28] The definition of a de novo hearing is a decision of the matter anew, giving no deference to findings and conclusions previously made by the judge.[29] The Board, on de novo review, makes its own factual findings.[30] The Board is as equally capable as a judge in reviewing the evidence.[31]

The three issues concern whether claimant proved injury to his tailbone, the nature and extent of his disability and whether he is entitled to future medical treatment.

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[27] ALJ Award at 10-11.

[28] See *Helms v. Pendergast*, 21 Kan. App. 2d 303, 899 P.2d 501 (1995).

[29] See *In re Tax Appeal of Colorado Interstate Gas Co.*, 270 Kan. 303, 14 P.3d 1099 (2000).

[30] See *Berberich v. U.S.D. 609 S.E. Ks. Reg'l Educ. Ctr.*, No. 97,463, 2007 WL 3341766 (Kansas Court of Appeals unpublished opinion filed Nov. 9, 2007).

[31] See *Moore v. Venture Corp.*, No. 110,883, 2015 WL 402753 (Kansas Court of Appeals published decision dated Jan. 30, 2015).

1. Claimant sustained personal injury to his tailbone.

An employer is liable to pay compensation to an employee incurring personal injury by accident arising out of and in the course of employment.[32] The burden of proving an award of compensation is on the claimant. The burden of proof is based on a preponderance of the credible evidence standard – that a party's position on an issue is more probably true than not true on the basis of the whole record.[33]

K.S.A. 2012 Supp. 44-508(f)(1) provides:

> "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.[34]

Respondent argues claimant failed to prove personal injury because he did not prove a lesion or change in the physical structure of his body. The judge agreed, indicating: (1) imaging studies did not show a structural change in claimant's tailbone or low back and (2) pain is not enough to prove personal injury.

The Board respectfully disagrees. First, K.S.A. 2012 Supp. 44-508(f)(1) does not require lesions or changes in the physical structure of the body to be verified by imaging studies, such as an x-ray or MRI scan. Second, the statute does not state pain is insufficient proof of an injury. To be clear, pain is subjective and cannot be "validated or measured objectively."[35] A complaint of pain can be viewed with "suspicion and disbelief."[36] Pain complaints alone do not necessarily mean an injury occurred. Despite the potential need for caution against baldly accepting pain complaints as valid, a claimant's report of pain should be considered along with all other facts in assessing whether an injury occurred. It is consistent for an injured person to complain about pain. The *absence* of pain complaints would go further to disprove an injury than the *presence* of pain complaints. We also view the facts as establishing claimant proved he sustained personal injury as defined by K.S.A. 2012 Supp. 44-508(f)(1).

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[32] K.S.A. 2012 Supp. 44-501b(b).

[33] K.S.A. 2012 Supp. 44-501b(c).

[34] The predecessor statute defining personal injury, K.S.A. 2010 Supp. 44-508(e), also stated a "personal injury" or "injury" is a "lesion or change in the physical structure of the body, causing damage or harm thereto." However, the statute in effect before May 15, 2011 noted, "It is not essential that such lesion or change be of such character as to present external or visible signs of its existence." Such language is omitted in the current version of the statute.

[35] *Guides* at 303.

[36] *Id.* Of note, the judge did not indicate claimant was or was not a credible witness.

The Board places little weight in Dr. Bailey's opinion that claimant did not have a coccyx or tailbone injury. Dr. Bailey stated claimant's complaints did not correlate to his accident, perhaps because his report did not state claimant's tailbone hit a concrete floor. Claimant's testimony that his tailbone struck a concrete floor is credible. We are not sure why Dr. Bailey's report would not reflect such history. Dr. Bailey may also have concluded claimant did not have a tailbone injury based on his notation claimant "subsequently complained of some back pain over time." Such information suggests claimant's complaints, apart from his left knee, were belated, which is also against the weight of the credible evidence. Based on the credible evidence before us, claimant's tailbone pain began with his accidental injury.

Dr. Bailey indicated claimant had subjective pain complaints without evidence of significant abnormality. Dr. Bailey placed significant weight in the absence of significant problems noted on imaging studies, but he nonetheless brought up treatment modalities consisting of injections and even surgical removal of claimant's coccyx. It is counterintuitive for Dr. Bailey to discuss medical treatment for a non-existent injury.

Dr. Prostic indicated a person with claimant's complaints "usually have injury . . . either to the joint between the sacrum and coccyx or to the ligaments that attach to the coccyx." These sort of injuries would be "any lesion or change in the physical structure of the body, causing damage or harm thereto." Dr. Prostic noted patients with claimant's complaints typically have inflammation that can be relieved by injections. Both Dr. Bailey and Dr. Jones brought up the possibility of injections. Injections were suggested to relieve an actual injury. "Usually" and "typically" are similar to the more probably true than not true standard of proof. Dr. Prostic could have been clearer that claimant, and not just other patients with his complaints, likely has an ailment affecting either the joint between the sacrum and coccyx or to the ligaments that attach to the coccyx or inflammation. Still, the Board concludes the evidence shows claimant proved personal injury involving his tailbone.

2. Claimant has a 2.5% whole body impairment for his tailbone and a 7.5% left leg impairment for a combined 5.5% whole body impairment.

K.S.A. 2012 Supp. 44-508(u) provides:

> "Functional impairment" means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of impairment, if the impairment is contained therein.[37]

[37] K.S.A. 2012 Supp. 44-510d(b)(23) and K.S.A. 2012 Supp. 44-510e(a)(2)(B) also state impairment for injuries are to be "determined using the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein."

The determination of the existence, extent and duration of the injured worker's incapacity is left to the trier of fact.[38] The trier of fact must decide which testimony is more accurate and/or credible and adjust medical, lay and other testimony that may be relevant to the question of disability. The trier of fact is "free to consider all of the evidence and decide for itself the percentage of disability. The numbers testified to by the physicians are not absolutely controlling."[39]

Tailbone Impairment

Considering all of the evidence, the Board concludes claimant has a 2.5% whole body impairment for his coccyx or tailbone injury. Such rating is between Dr. Prostic's 5% rating and Dr. Bailey's 0% rating.

A potential problem in this case is that both Dr. Prostic and Dr. Bailey used the DRE Method applicable to low back injuries to address claimant's coccyx or tailbone impairment. The *Guides* differentiate between the lumbosacral spine and the pelvis, which includes the coccyx and the sacrum. Page 13 of the *Guides* states the spine and pelvis are each considered a unit of the whole person and further:

> Normally the spine has 24 vertebrae. The cervical region has seven vertebrae, C 1 through C 7; the thoracic region has 12 vertebrae, T 1 through T 12; and the lumbar region has five vertebrae, L 1 through L 5.
>
> The pelvis is composed of the pubis, ischium, and ilium, which form its side and front, and the sacrum and coccyx, which form its posterior portion.

The *Guides* provide methods for rating the lumbosacral spine using the Diagnosis-related Estimates Model (DRE) and the Range of Motion Model. Separately, page 131 of the *Guides*, section 3.4, provides ratings for *selected* disorders of the pelvis, including ratings for a *fractured* coccyx or *fractured* sacrum.

Because the *Guides* treat the spine and pelvis separately and the sacrum and the coccyx are not considered part of the spine, it can be argued the physicians erred by rating claimant using the DRE Method for lumbosacral impairment. However, if claimant's impairment is not covered in the *Guides*, a doctor may use his own judgment to assess a claimant's impairment.[40]

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[38] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 522 P.2d 395 (1974).

[39] *Tovar v. IBP, Inc.*, 15 Kan. App. 2d 782, Syl. ¶ 1, 817 P.2d 212, *rev. denied* 249 Kan. 778 (1991).

[40] K.S.A. 44-510e(a); See *Smith v. Sophie's Catering & Deli Inc.*, No. 99,713, 2009 WL 596551 (Kansas Court of Appeals unpublished opinion filed Mar. 6, 2009), *publication denied* Nov. 5, 2010, and *Kinser v. Topeka Tree Care, Inc.*, No. 1,014,332, 2006 WL 2632002 (Kan. WCAB Aug. 1, 2006).

Dr. Prostic testified claimant's "sacrococcygeal difficulty" impairment was best represented by DRE Lumbosacral Category II, a 5% whole body impairment. Dr. Prostic testified the *Guides* do not address coccyx impairment. He was incorrect because the *Guides* address coccyx fractures. However, the *Guides* do not specifically address "sacrococcygeal difficulty" where a fracture is unproven. Therefore, because the *Guides* do not address claimant's impairment, Dr. Prostic had latitude in formulating a rating using his own judgment. Analogizing claimant's impairment as equivalent to DRE Lumbosacral Category II would be within his discretion.

We do not put full credit in the ratings from Drs. Bailey and Prostic. Dr. Bailey's 0% rating was predicated on claimant having no injury whatsoever and without knowledge of claimant's ongoing complaints of tailbone pain. While Dr. Bailey's rating report states he conducted a full examination of claimant's low back and tailbone, his examination conducted 16 months earlier contains little mention of testing the Board typically sees in thousands of back evaluations, such as palpation to check for tenderness or range of motion testing.[41] Conversely, Dr. Prostic rating is excessive. The *Guides* state a 5% rating is appropriate for a fractured and symptomatic coccyx,[42] a condition claimant does not possess. The Board concludes claimant's tailbone impairment is between the ratings from Drs. Prostic and Bailey. Claimant's whole body impairment for his tailbone is 2.5%.

Left Leg Impairment

Dr. Jones rationalizes he would not have released claimant to heavy work if claimant had any muscle atrophy. Dr. Jones also testified claimant was 100% functional in all activities at his last evaluation, and someone with 100% ability to engage in all activities would have no decreased muscle tone. However, Dr. Jones' records do not state claimant was 100% functional or that he had normal muscle tone. The fact Dr. Jones rated claimant for a functional impairment suggests claimant is not realistically 100% functional.

Dr. Prostic measured the circumference of claimant's thighs and determined claimant's injured left leg was smaller than his uninjured right leg. Dr. Jones' records contain no measurements for muscle loss or atrophy. Dr. Prostic's measurements are more reliable than Dr. Jones' belief claimant had no muscle atrophy. The Board concludes claimant's thigh muscle atrophy is more probably than not related to his accidental injury.

Respondent criticizes Dr. Prostic's rating because a small portion of such rating is based on a rating for a partial meniscectomy. However, the *Guides* do not appear to have a specific method for rating a chondroplasty, so Dr. Prostic had the freedom to rate claimant using a surgery he viewed as analogous.

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[41] Dr. Bailey's examination report did note tests for spinal cord or disc injury, such as reflex testing and the straight leg raise test.

[42] See *Guides* at 131.

The Board gives equal weight to the ratings from the competing experts. Claimant has a 7.5% impairment to his left leg. This converts to a 3% whole body rating.

While Dr. Prostic stated claimant's left calf atrophy was due to the accidental injury, such statement is moot in terms of claimant's functional impairment. Dr. Prostic's 10% lower leg rating was based on claimant's knee surgery being comparable to a 2% rating for a partial meniscectomy and an 8% rating for left thigh atrophy. The evidence does not show Dr. Prostic's lower extremity rating was based on claimant's calf atrophy.[43]

Combining claimant's 2.5% rating for his tailbone and a 3% whole body rating for his left leg results in claimant having an overall 5.5% whole body impairment.

3. Claimant is not entitled to future medical treatment.

K.S.A. 2012 Supp. 44-510h(e) states:

> It is presumed that the employer's obligation to provide the services of a health care provider . . . shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

Claimant reached MMI. Dr. Jones did not recommend additional treatment for claimant's left knee. Dr. Bailey did not recommend additional treatment for claimant's low back or tailbone. Dr. Prostic recommended strengthening exercises, general aerobics and core strengthening, and the possibility of anti-inflammatory and analgesic medicines without specifying if claimant's need for exercise would be part of a home exercise program or if his possible need for medication would be for over-the-counter medication.

Both Dr. Bailey and Dr. Prostic recommended against surgical removal of claimant's coccyx. Dr. Bailey recommended against injecting claimant's coccyx, while Dr. Prostic wrote an injection was a possibility. Claimant testified Dr. Prostic advised against a coccyx injection. In any event, with an eye toward the specific language of K.S.A. 2012 Supp. 44-510h(e), Dr. Prostic did not recommend, more probably than not, that claimant "will" need a coccyx injection in the future. A medical *possibility* is not a medical *probability*.[44]

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[43] As an aside, even if Dr. Prostic's rating accounted for claimant's left calf atrophy, the Kansas Workers Compensation Act does not require that he or claimant prove the respective sizes of claimant's calves before his injury. As a practical matter, such measurements would rarely be taken pre-injury. Moreover, the burden of proving preexisting impairment, as based on case law, belongs to respondent. *Hanson v. Logan U.S.D. 326*, 28 Kan. App. 2d 92, 11 P.3d 1184 (2000), *rev. denied* 270 Kan. 898 (2001).

[44] See *Karle v. Board of County Com'rs of Kearny County*, 188 Kan. 800, 806-07, 366 P.2d 241 (1961).

The dissent notes Dr. Jones recommended an injection for claimant's back from a physiatrist and respondent ignored such suggestion, opting to send claimant to Dr. Bailey. Whether respondent should have sent claimant to a physiatrist well over two years ago does not address the current issue of future medical treatment. If claimant needed additional medical treatment a couple years ago, a preliminary hearing to obtain such benefit would have been the appropriate remedy. No such treatment was pursued.

The dissent notes claimant's complaints of back and tailbone pain establish that he will need medical treatment in the future. If that assessment is accurate, the presumption against future medical treatment in K.S.A. 2012 Supp. 44-510h(e) would never apply if a claimant simply voiced complaints.

The dissent also notes it would be difficult to find claimant to be at MMI if he received no treatment for his tailbone. However, claimant presented no proof he was not at MMI. As noted above, if claimant was not at MMI and needed additional medical treatment, he could have proceeded to a preliminary hearing years ago.

Two of the three physicians indicated claimant did not need additional medical treatment. No doctor testified it was more probably true than not that claimant "will" require future "medical treatment" as defined by K.S.A. 2012 Supp. 44-510h(e). It was claimant's burden to prove the recommendations by Dr. Prostic involved something more than home exercise or over-the-counter medication. He did not do so. The greater weight of the credible medical evidence is that claimant will not need future medical treatment. Claimant did not overcome the presumption contained in K.S.A. 2012 Supp. 44-510h(e).

CONCLUSIONS

Having carefully reviewed the entire evidentiary file, the Board concludes:

1. Claimant proved personal injury to his tailbone.

2. Claimant has a 5.5% whole body impairment as a result of his accidental injury.

3. Claimant is not entitled to future medical treatment.

AWARD

WHEREFORE, the Board modifies the October 14, 2014 Award as listed above.

Claimant is entitled to 10.14 weeks of temporary total disability compensation at the rate of $340.98 per week or $3,457.54 followed by 22.83 weeks of permanent partial disability compensation at the rate of $340.98 per week or $7,784.57 for a 5.5% functional disability, making a total award of $11,242.11, which is ordered paid in one lump sum less amounts previously paid.

IT IS SO ORDERED.

Dated this _____ day of February, 2015.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

DISSENT

The undersigned Board Member dissents from the majority opinion.

Dr. Jones, the only testifying physician who provided any medical treatment, repeatedly suggested claimant be seen by a physiatrist for non-surgical treatment of his low back, which was really a tailbone problem. Respondent did not follow the recommendation of the treating physician. Instead, respondent simply sent claimant to Dr. Bailey for what turned out to be a one-time evaluation. In fact, respondent provided claimant with no treatment whatsoever for his tailbone. All of the doctors indicated claimant is a candidate for injections and two physicians raised even the possibility of surgery, even though the risk of infection may outweigh the benefit.

The dissent recognizes the presumption against future medical treatment set forth in K.S.A. 2012 Supp. 44-510h(e) must be overcome with medical evidence. Claimant complained to Dr. Jones on May 21, 2013, of low back pain rated as a 6 on a 0-10 pain scale. Claimant also complained of having low back pain during his evaluations by Drs. Bailey and Prostic. He also complained of having shooting pain in his tailbone during certain activities. These facts corroborate the medical evidence that, more probably than not, claimant will need future medical treatment for his tailbone injury for which the majority found claimant sustained a permanent functional impairment.

It is also difficult to say claimant reached MMI when he received no treatment for his tailbone. Dr. Bailey's opinion claimant reached MMI was based on what he "believed" without additional evaluation of claimant some 16 months after his only evaluation of claimant.

Claimant has overcome the presumption that he will not require additional medical treatment in the future. He most likely will require medical treatment in the future.

_____
BOARD MEMBER

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